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PRTF Alternative CHANCE Waiver Overview

Case Management Training 2013

This training will answer the following:

- What is the PRTF Alternative CHANCE Waiver ?
- What services are available under the Waiver?
- What is Case Management?
- Who can provide Case Management?
- What does the Service Plan Development Team do and who are it's members?

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This training will answer the following:

- What is an Individual Plan of Care?
- What information is required to be included in the Plan of Care?
- How do services get authorized?
- Who does the plan need to be shared with?
- What does the Case Manager do when they aren't writing or developing a Plan of Care?
- What services are billable under Case Management?
- Can families and youth exit the program?
- What should be done when families and youth exit the program?

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The CHANCE Waiver

The purpose of this waiver is to provide home and community-based supports and services to children who have been diagnosed with Serious Emotional Disturbance (SED) and/or mental illness who would otherwise be served in Psychiatric Residential Treatment Facilities (PRTF)

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Eligibility Requirements

- Diagnosed with SED
- Between ages four and 19
- Has an identifiable need for waiver services
- Medicaid-eligible
- Meets PRTF Level of Care eligibility requirements
  - Determined by annual CALOCUS Assessment (Billing Ticket required)
  - Must be completed by professional who has been certified by SCDHHS in administering the CALOCUS.

Freedom of Choice

Youth and families have the choice of placing youth who meet Level of Care in a PRTF or electing to participate in Home and Community based services through 1915(c) of the social security act.

If Home and Community Based services are selected, youth and families have services provided to them by the qualified Waiver provider of their choice

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Enrollment Process

- Enrollment is **NO LONGER OPENED**
- In an effort to sustain the waiver beyond September 30, 2012, South Carolina applied for waiver renewal, which would allow enrolled participants an opportunity to continue their demonstration period.
- The Centers for Medicare and Medicaid Services (CMS) approved South Carolina's 1915(c) PRTF Alternative CHANCE Waiver renewal request, so that participants who are enrolled in the waiver after October 1, 2012 can continue utilizing the home- and community-based services.
- As participants are discharged from the waiver, new slots will not be added.
- The PRTF Alternative CHANCE Waiver will expire on September 30, 2014.
  - At that time, any remaining waiver participants will be transitioned into appropriate supports and services based on their needs.

Current Waiver Services

- Case Management – required for all Waiver participants
- Pre-Vocational Services
- Respite Services (per diem & daily rates)
- Customized goods and services
- Peer Support Services
- Wraparound Behavioral Intentions
- Wraparound Community Supports
- Wraparound Independent Living
- Wraparound Caregiver Support
- Intensive Family Services

Case Management Service Definition

Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring and the coordination of the provision of services included in the participant's plan of care.

Case Manager Staff Qualifications:

- A master's degree in social work, psychology, counseling, special education, or in a closely related field
- A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities; or
- A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities; or
- A registered nurse licensed to practice in South Carolina and have at least three years of experience performing clinical or case work activities

The Service Plan Development Team

- Meets every 90 days or more as needed to develop Individualized Plan of Care (IPOC)
- Consists of the youth, family, case manager, all waiver service providers and anyone else who the family chooses to participate
- Facilitated by the Case Manager with input from family

The Service Plan Development Team

- Discusses progress, or lack of progress, towards goals
- Collaborates to determine support needs and appropriate services to keep the youth in the least restrictive environment
- Is vital to the success of person centered approach

Service Plan Development Requirements

- The entire Service Plan Development Team are to be informed of and participate in POC Meetings
- Phone and video conferences are to be utilized if physical attendance is not feasible
- Physical attendance of Service Plan Development Team meetings must be documented
- Comprehensive lists are required to document attendance via telephone or video
- Desk reviews should be utilized if Service Plan Development Meetings cannot be held for justifiable reasons within 90 day time frame and prior to expiration of current plan

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Individualized Plan of Care (Treatment Plan)

- The IPOC is developed during the Service Plan Development Meeting and will include:

1. **A Budget Form** that reflects the amount that will be spent to provide the services listed.
2. **A Service Authorization Form** that will be signed by DHHS staff to authorize services requested
3. **A Plan of Care (POC)** which serves as the map for services that the providers use to drive supports and services to Waiver participants
4. **90 Day Progress Summary** which summarizes the clients progress over the previous 90 days and reviews SPD meeting
5. **A Crisis Plan** that will clearly state the protocol and responsibility for handling crises, including after-hour calls.
6. **SPD Team Meeting attendance documentation** which documents attendees of SPD meeting

Individualized Plan of Care

IPOC Submissions (Every 90 Days):

- Submitted IPOCs must include a Budget Form, Service Authorization Form, Progress Summary, and a Plan of Care (POC) .
- Crisis Plans and Service Plan Development Team Participation Records should be completed during POC Meetings and should be readily available in each client's case management file, but **do not have to be submitted to DHHS**.

IPOC Deadlines:

- All IPOCs must be **submitted prior to the expiration of the current IPOC**
- Desk reviews should be utilized if Service Plan Development Meetings cannot be held for justifiable reasons
  - Desk reviews require all IPOC documents to be submitted along with justification as to why the meeting could not be held. There should also be evidence of failed attempts to schedule/hold meetings.
  - SPD team and families should be informed/updated as soon as possible

IPOC Documents: Budget Forms

Ensure that:

- You are submitting the required, updated Budget Form as of April 1, 2013
- Plan dates are documented correctly (Beginning and Ending)
- Participants' Medicaid #s are correct
- Forms are signed and dated by all members of the SPD Team

IPOC Documents: Service Authorization Forms

Ensure:

- Participants' Medicaid #s are documented correctly
- Participants' DOBs are correct
- All services listed on Budget Form are documented on the Service Authorization Form
- "# Units Requested" and "Total Units Requested " columns are identical and are a duplicate of the units requested on the Budget Form
- Form is signed and dated by Case Manager

IPOC Documents: The Plan of Care

- Is developed every 90 days following the Service Plan Development meeting
- Is based on the recommendations from the Level of Care and the Service Plan Development team
- Is written by the Case Manager in collaboration with the Service Plan Development team

IPOC Documents: Plan of Care

- The Plan of Care document includes appropriate identifying information: the participant's name, Medicaid number, date of birth and date of the plan.
- Identifies strengths and support needs for the waiver participants.
- Identifies the Provider of the service, type of service, frequency and duration of the service.

IPOC Documents: Plan of Care

- Identifies goals for each service type that the youth, their family and the service plan development team have identified through the service plan development process

- Has Case Manager signature, title and date as well as signature of the youth and family

- The Plan of Care must be distributed to the family and service providers once it has been approved by DHHS

IPOC Documents: Forms

- 90 Day Progress Summary
  - Should document clients' progress based upon goals, services provided, and recommendations
- Crisis Plan
  - States the protocol and responsibility for handling crises, including after-hour calls.
- SPD Team Meeting attendance documentation
  - Serves as a "sign-in" sheet for all attendees of SPD Meeting
  - Should include name, signature, and date

Authorization to Provide Services

- The signed POC, budget and authorization forms along with the 90 Day Summary must be submitted to DHHS
- DHHS will review to ensure required elements of the IPOC are included
- DHHS will authorize the provision of services based on the needs of each individual child
- Services will be subject to non-approval if IPOCs are not submitted prior to the expiration of the current IPOC in DHHS files
- Any services provided and/or billed for which have not been authorized by DHHS will be subject to recoupment

Distribution

Once plans have been approved by DHHS the approved authorizations will be sent to the noted case manager

<u>Responsibilities</u>:

- All case managing agencies are responsible for distributing approved authorizations to service providers and families served
- Youth and families should know and understand what is in their Plan of Care to improve treatment outcomes and improve buy in from families
- All direct service providers are responsible for obtaining approved service authorizations from the case manager prior to rendering services.
- Services which are provided without proper documentation are subject to recoupment.

Distribution

- **<u>Checks and balances system:</u>**
- All members of the SPD Team are to ensure that what was agreed upon at the Service Plan Development meeting was appropriately documented.
- Discrepancies should be addressed as soon as possible with the Case Manager to discuss the issue and have any errors corrected.
- Failure to address errors regarding the IPOC may result in service providers being held accountable to the error/misstatements in the final POC.

Case Manager Responsibilities:

- Educating families about available services
- Tracking and documenting the family's progress on treatment goals
- Keeping track of due dates for the Plan of Care and LOC Assessment to ensure that they are completed and submitted prior to the expiration of the current document on file
- Coordinating and facilitating the Service Plan Development team meetings
- Writing the Plan of Care based on the Service Plan Development Team meeting and LOC recommendations

Case Manager Responsibilities:

- Relationship building with the youth and family to develop trust and better meet the needs of the family
- Advocate on behalf of the youth and the families
- Coordinating needed services to meet the needs of the youth and the family
- Collect and report all follow up minimum data set requirements
- Contact the family at least twice a month to monitor and oversee that the supports and services in place are meeting the needs of the youth and the family – **one of these contacts MUST be face to face**

Case Manager Responsibilities:

- Support the family to schedule appointments related to supports and services for the youth
- Provide case management services to waiver participants but no other waiver services may be provided to that same participant by the Case Manager so long as the participant is on their caseload
  - Case Managers may provide other waiver services to children who are not on their caseloads.

Service Provision

- Services are provided pursuant of the Plan of Care – billable service time addresses goals from the Plan of Care

- **Not all Case Management activities are billable activities**

Service Provision

Allowable/billable Case Management services include activities in which the Case Manager has a direct interaction with the youth/family that address one of the following:

- Educating families on available services;
- coordinating services;
- referral/linkage to supports;
- monitoring/follow up on services

Billable Services: Case Management

To bill for Case Management services there must be documentation of at least one face to face contact and at least one phone contact. Case Management services are billed in 15 minute units.

Billable Services: Case Management

Billable services include face to face contact, phone conversations or other direct interaction with the youth and/or their family member. Other required case management activities are built into the Case Management rate and are not billable activities. These other required activities can be important to the treatment of the child and should be documented as part of treatment progress.

Discharging from the Waiver

- Participants and families reserve the right to exit or not participate in the waiver at any time
- Case Managers must notify DHHS of discharges upon notification by waiver participants or families
- Case Manager must notify direct service providers of discharges
- Case Managers must submit discharge documentation to DHHS as soon as possible

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Resources

- SCDHHS. (2013). South Carolina Health Connections (Medicaid) Provider Manual: PRTF Alternative CHANCE Waiver. Columbia: Blue Cross Blue Shield.
- South Carolina Department of Health and Human Services website: http://www.scdhhs.gov/
- **PRTF Alternative CHANCE Waiver website: https://msp.scdhhs.gov/chance/**
- Federation of Families website: http://fedfamsc.org/
- Center for Medicaid and Medicare services website: http://www.cms.gov/

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Resources

- South Carolina Legislature website: http://www.scstatehouse.gov/code/statmast.php
- Electronic Code of Federal regulations website: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=eabc498daa8a3a2689db074a01bdb045&c=ecfr&tpl=%2Findex.tpl
- The Social Security Act website: http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm

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